NEW PATIENT FORM

(all information is strictly confidential and will remain in the office)

First Name: ______________________________

Last Name: ______________________________

Preferred Name: ______________________________

Address: ______________________________

City: __________________ Postal Code: __________

Date of Birth: ______________ Age: _____ Sex: _____

Marital Status: ______________________________

Occupation: ______________________________

Employer: ______________________________

Email: ______________________________

Cell Phone: ______________________________

Home Phone: ______________________________

Work Phone: ______________________________

Preferred Contact Method: (circle)
EMAIL / PHONE / TEXT

If phone or text, which number? (circle)
CELL / HOME / WORK

How did you hear about our office? ______________

____

If the patient is under 18 years of age

Parent/Guardian name: ______________________________ Phone: ______________

Parent/Guardian name: ______________________________ Phone: ______________

Who is financially responsible for this account if the patient is under 18 years old? ______________

Emergency Contact

Name: ______________________________ Relationship: ______________________________

Home Phone: ______________ Mobile: ______________ Work Phone: ______________

Medical Information

Medical Doctor: ______________________________ Phone: ______________________________

Date of last physical exam: ______________ Do you consider yourself to be in good health? __________

Are you presently under the care of a medical doctor? If yes, please specify: ______________________________

Please list any medication you currently take, including non-prescription, herbal supplements, and/or vitamins:

____

Please list any allergies or if you have had any reactions (to medications, anaesthetics, metals, latex, antibiotics, pain killers, dairy etc.):

____

Do you have to take any antibiotics? If yes, why? ______________________________

Have you had heart surgery? If yes, please specify: ______________________________

Do you have any artificial prosthesis (joints, heart valve, etc.)? If yes, please specify: ______________________________

Do you have abnormal bleeding? ______________ Do you become breathless easily? __________

Do you smoke? If yes, how much? ________________________ Do you take recreational drugs?___________________

Are you taking birth control pills? __________________________ Are you pregnant?______________________________

Do you have any of the following? Please tick all that apply:

___ Heart Murmur	___ Sinus Problems	___ Liver Disease	___ Nervous Problems
___ Heart Trouble	___ Headaches	___ Kidney Trouble	___ Epilepsy
___ Chest Pain	___ Ulcer	___ Asthma	___ Psychiatric Care
___ Blood Disorders	___ Herpes	___ Tuberculosis	___ Antidepressants
___ High Blood Pressure	___ Venereal Disease	___ Emphysema	___ Alcohol/Drug Dependency
___ Low Blood Pressure	___ Hepatitis Type?______	___ Rheumatic Fever	___ Cancer
___ Anemia	___ HIV/AIDs Tested?_____	___ Digestive Disorders	___ Chemotherapy
___ Stroke	___ Thyroid Problems	___ Glaucoma	___ Radiation Therapy
___ Arthritis	___ Diabetes	___ Head/Neck Injuries	___ Other: ________

Dental History

Are you having any discomfort at this time? If yes, please specify:

Have you had regular care from a dentist? ___________ When was your last dental visit? ____________________

Name of previous Dental office? ____________________ Phone Number: _____________________

Is there often bleeding when you floss? _____________ Have you ever been given local anesthetic? _________

Are you aware of any lump or swelling in your mouth? ____

Are you satisfied with the appearance of your teeth? ____

Are you tense during dental visits? ____

Insurance Information

1st Insurance Company: ____________________________ Policy # ______________

Name of Policy Holder: ____________________________ ID # ________________________________

Date of Birth: ________________________ Employer: ____

2nd Insurance Company: ____________________________ Policy # ______________

Name of Policy Holder: ____________________________ ID # ________________________________

Date of Birth: ________________________ Employer: __________________________________

Office Policy/Assignment and Release

If you are unable to keep the appointment, please give us at least 48 hours advance notice or we may charge a cancellation fee for time lost

This is to certify that I, the undersigned, consent to the performing of the dental procedures agreed to be necessary or advisable, and I will assume responsibility for fees associated with those procedures.

Patient/Parent/Guardian :____DATE:_____________________

SIGNATURE:________________________________